



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

DATE OF REVIEW: 8/29/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 12 sessions for lumbar spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas State Licensed MD Board Certified Orthopedic Surgeon & Spine Surgeon

REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Assignment to 8/9/2012
2. Notice of assignment to URA 8/9/2012
3. Confirmation of Receipt of a Request for a Review by an IRO 8/9/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 8/9/2012
6. Letter from attorney 8/9/2012, letter from insurance company 8/8/2012, 7/26/2012, , clinical encounter summaries 7/13/2012, progress notes 6/20/2012, 6/5/2012, 5/3/2012, 4/9/2012, 3/27/2012.

PATIENT CLINICAL HISTORY:

The patient is a male who was noted to have been injured on due to a fall. There was persistent back pain documented, despite 15 PT sessions. The records did not reflect a neurological deficit,



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although tenderness was noted in the paraspinal muscles. The documents from the treating provider's office and the therapy facility, in which he was treated were reviewed.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

With minimal subjective and objective thoracolumbar improvement post guideline-associated number of physical therapy visits, additional formal supervised physical therapy is not reasonable and medically necessary, as per ODG criteria. Rationale for other than a prescribed and self-administered PT protocol has not been submitted. The 12 sessions of physical therapy for the lumbar has been upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)